Consent for Disclosure to Family Member and/or Personal Representative

Patient Name: ______________________________

Address: ______________________________

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I have agreed to let certain individuals participate in discussion and decisions related to my dental care. Therefore, I hereby give permission for Shelby Dental Care Center and Dr. Brenton L. Young, Dr. Pauline E. Cahill or Dr. Jessica H. Lackey and their staff to disclose my personal health information to the following individuals(s):

Name: ______________________________

Relationship to Patient: ______________________________

Name: ______________________________

Relationship to Patient: ______________________________

Name: ______________________________

Relationship to Patient: ______________________________

Conditions for Disclosure (Check the items that apply):

❏ The practice may disclose my personal health information to the individual(s) above ONLY in my presence.

❏ The practice may disclose my medical information to the individual(s) above in discussions in my presence and when I am not physically present, including disclosures by phone, fax, email or regular mail.

❏ Other Conditions of Disclosure:

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RIGHTS OF THE PATIENT

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Marie Gantt, privacy official. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. The authorization shall be in effect until revoked by the patient.

Signature:

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(Patient or Guardian)

Date: ______________________________

Witness Signature:

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Title/Position: ______________________________

Print Name of Witness: ______________________________

Date: ______________________________